

Comparison of Statewide Plans 2012

Effective July 1, 2012 or October 1, 2012



The Local Choice 2012 Comparison of Statewide Plans

| | Key Advantage Expanded | | | Key Advantage 250 | | |
|---|---|--|--|---|--|--|
| Plan year deductible (Key Advantage: applies to certain medical services as indicated on chart) (HDHP: applies to medical, behavioral health, and prescription drug services) | In-Network: One Person \$100 Out-of-Network: \$200 | Two People <i>See Family</i> <i>See Family</i> | Family \$200 \$400 | In-Network: One Person \$250 Out-of-Network: \$500 | Two People <i>See Family</i> <i>See Family</i> | Family \$500 \$1,000 |
| Plan Year Out-of-pocket expense limit | In-Network: One Person \$1,000 Out-of-Network: \$2,000 | Two People <i>See Family</i> <i>See Family</i> | Family \$2,000 \$4,000 | In-Network: One Person \$2,000 Out-of-Network: \$4,000 | Two People <i>See Family</i> <i>See Family</i> | Family \$4,000 \$8,000 |
| Out-of-network benefits | Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services. | | | Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services. | | |
| Medical care when traveling | Included | | | Included | | |
| Lifetime maximum | Unlimited | | | Unlimited | | |
| Covered Services | In-Network You Pay | | | In-Network You Pay | | |
| Ambulance travel | 20% coinsurance after deductible | | | 20% coinsurance after deductible | | |
| Autism Spectrum Disorder 2 years to 6 years \$35,000 Annual Limit | Copayment/coinsurance determined by service received | | | Copayment/coinsurance determined by service received | | |
| Behavioral health and EAP <i>Inpatient treatment</i> • Facility services • Professional provider services <i>Outpatient professional provider visits</i> | \$200 copayment per stay \$0 \$15 copayment | | | \$300 copayment per stay \$0 \$20 copayment | | |
| Employee Assistance Program (EAP) 4 visits per incident (per rolling 12 months) | \$0 | | | \$0 | | |
| Dental <i>Dental plan year deductible</i> <i>Plan year maximum (except Orthodontics)</i> <i>Diagnostic and preventive services</i> <i>Basic dental care</i> <i>Major dental care</i> <i>Orthodontic services</i> | One Person \$25 \$1,500 \$0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with \$1,500 lifetime maximum | Two People \$50 \$75 | Family \$75 \$75 | One Person \$25 \$1,200 \$0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with \$1,200 lifetime maximum | Two People \$50 \$50 | Family \$75 \$75 |
| Diabetic Education | \$0 | | | \$0 | | |
| Diabetic Equipment | 20% coinsurance after deductible | | | 20% coinsurance after deductible | | |
| Diabetic Supplies - see Outpatient prescription drugs | | | | | | |
| Diagnostic tests and x-rays (for specific conditions or diseases at a doctor's office, emergency room or outpatient hospital department) | 10% coinsurance, no deductible | | | 10% coinsurance after deductible | | |
| Doctor visits – on an outpatient basis <i>Primary care physicians</i> <i>Specialty care providers</i> | \$15 copayment \$25 copayment | | | \$20 copayment \$35 copayment | | |
| Early Intervention Services | Copayment/coinsurance determined by service received | | | Copayment/coinsurance determined by service received | | |

| Key Advantage 500 | | | Key Advantage 1000 | | | High Deductible Health Plan | | |
|--|------------|----------|--|------------|----------|--|------------|----------|
| In-Network: | | | In-Network: | | | | | |
| One Person | Two People | Family | One Person | Two People | Family | One Person | Two People | Family |
| \$500 | See Family | \$1,000 | \$1,000 | See Family | \$2,000 | \$1,500 | See Family | \$3,000 |
| Out-of-Network: | | | Out-of-Network: | | | | | |
| \$1,000 | See Family | \$2,000 | \$2,000 | See Family | \$4,000 | | | |
| In-Network: | | | In-Network: | | | | | |
| One Person | Two People | Family | One Person | Two People | Family | One Person | Two People | Family |
| \$3,000 | See Family | \$6,000 | \$4,000 | See Family | \$8,000 | \$5,000 | See Family | \$10,000 |
| Out-of-Network: | | | Out-of-Network: | | | | | |
| \$6,000 | See Family | \$12,000 | \$8,000 | See Family | \$16,000 | | | |
| Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services. | | | Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services. | | | No coverage, except in emergency. | | |
| Included | | | Included | | | Included | | |
| Unlimited | | | Unlimited | | | Unlimited | | |
| In-Network You Pay | | | In-Network You Pay | | | In-Network You Pay | | |
| 20% coinsurance after deductible | | | 20% coinsurance after deductible | | | 20% coinsurance after deductible | | |
| Copayment/coinsurance determined by service received | | | Copayment/coinsurance determined by service received | | | 20% coinsurance after deductible | | |
| 20% coinsurance per stay after deductible | | | 20% coinsurance per stay after deductible | | | 20% coinsurance after deductible | | |
| \$0 | | | \$0 | | | 20% coinsurance after deductible | | |
| \$25 copayment | | | \$25 copayment | | | 20% coinsurance after deductible | | |
| \$0 | | | \$0 | | | \$0 | | |
| One Person | Two People | Family | One Person | Two People | Family | One Person | Two People | Family |
| \$25 | \$50 | \$75 | \$25 | \$50 | \$75 | \$25 | \$50 | \$75 |
| \$1,200 | | | \$1,200 | | | \$1,500 | | |
| \$0, no deductible | | | \$0, no deductible | | | \$0, no deductible | | |
| 20% coinsurance after dental deductible | | | 20% coinsurance after dental deductible | | | 20% coinsurance after dental deductible | | |
| 50% coinsurance after dental deductible | | | 50% coinsurance after dental deductible | | | 50% coinsurance after dental deductible | | |
| 50% coinsurance, no dental deductible, with \$1,200 lifetime maximum | | | 50% coinsurance, no dental deductible, with \$1,200 lifetime maximum | | | 50% coinsurance, no dental deductible, with \$1,500 lifetime maximum | | |
| \$0 | | | \$0 | | | 20% coinsurance after deductible | | |
| 20% coinsurance after deductible | | | 20% coinsurance after deductible | | | 20% coinsurance after deductible | | |
| 20% coinsurance after deductible | | | 20% coinsurance after deductible | | | 20% coinsurance after deductible | | |
| 20% coinsurance after deductible | | | 20% coinsurance after deductible | | | 20% coinsurance after deductible | | |
| \$25 copayment | | | \$25 copayment | | | 20% coinsurance after deductible | | |
| \$40 copayment | | | \$40 copayment | | | 20% coinsurance after deductible | | |
| Copayment/coinsurance determined by service received | | | Copayment/coinsurance determined by service received | | | 20% coinsurance after deductible | | |

The Local Choice 2012 Comparison of Statewide Plans (continued)

| Covered Services | Key Advantage Expanded In-Network You Pay | Key Advantage 250 In-Network You Pay |
|--|--|--|
| Emergency room visits <i>Facility services</i> <i>Professional provider services</i> <ul style="list-style-type: none"> • Primary care physicians • Specialty care providers <i>Diagnostic tests and x-rays</i> | \$100 copayment per visit (waived if admitted to hospital) \$15 copayment \$25 copayment 10% coinsurance, no deductible | \$150 copayment per visit (waived if admitted to hospital) \$20 copayment \$35 copayment 10% coinsurance after deductible |
| Home health services (90 visit plan year limit per member) | \$0 | \$0 |
| Home private duty nurse's services | 20% coinsurance after deductible | 20% coinsurance after deductible |
| Hospice care services | \$0 | \$0 |
| Hospital services <i>Inpatient treatment:</i> <ul style="list-style-type: none"> • Facility services • Professional provider services <ul style="list-style-type: none"> - Primary care physicians - Specialty care providers <i>Outpatient treatment</i> <ul style="list-style-type: none"> • Facility services • Professional provider services <ul style="list-style-type: none"> - Primary care physicians - Specialty care providers • Diagnostic tests and x-rays | \$200 copayment per stay \$0 \$0 \$100 copayment \$15 copayment \$25 copayment 10% coinsurance, no deductible | \$300 copayment per stay \$0 \$0 \$150 copayment \$20 copayment \$35 copayment 10% coinsurance after deductible |
| Infusion services <i>Facility services</i> <i>Professional provider services</i> <i>Home services</i> <i>Infusion medications -</i> <ul style="list-style-type: none"> • Outpatient settings • Home settings | 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible | 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible |
| Maternity <i>Professional provider services (prenatal & postnatal care)</i> <ul style="list-style-type: none"> • Primary care physicians • Specialty care providers <i>Delivery</i> <ul style="list-style-type: none"> • Primary care physicians • Specialty care providers <i>Hospital services for delivery (delivery room, anesthesia, routine nursing care for newborn)</i> <i>Outpatient diagnostic tests</i> | \$15 copayment \$25 copayment If your doctor submits one bill for delivery, prenatal and postnatal care services, there is no copayment required for physician care. If your doctor bills for these services separately, your payment responsibility will be determined by the services received. \$0 \$0 \$200 copayment per stay* 10% coinsurance, no deductible | \$20 copayment \$35 copayment \$0 \$0 \$300 copayment per stay* 10% coinsurance after deductible |
| Medical equipment, appliances, formulas, prosthetics and supplies | 20% coinsurance after deductible | 20% coinsurance after deductible |
| Outpatient prescription drugs - mandatory generic <i>Retail up to 34-day supply*</i> *You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments, or the coinsurance after the deductible <i>Home Delivery Services (Mail Order)</i> Covered drugs for up to a 90-day supply Diabetic Supplies | Tier 1 - \$10 copayment Tier 2 - \$20 copayment Tier 3 - \$35 copayment Tier 1 - \$20 copayment Tier 2 - \$40 copayment Tier 3 - \$70 copayment 20% coinsurance, no deductible | Tier 1 - \$10 copayment Tier 2 - \$20 copayment Tier 3 - \$35 copayment Tier 1 - \$20 copayment Tier 2 - \$40 copayment Tier 3 - \$70 copayment 20% coinsurance, no deductible |

*This plan will waive the hospital copayment if the member enrolls in the maternity management pre-natal program within the first trimester of pregnancy, has a dental cleaning during pregnancy and satisfactorily completes the program.

**You may select a frame greater than the covered allowance and receive a 20% discount for any additional cost over the allowance.

| Key Advantage 500 In-Network You Pay | Key Advantage 1000 In-Network You Pay | High Deductible Health Plan In-Network You Pay |
|---|---|--|
| 20% coinsurance after deductible | 20% coinsurance after deductible | 20% coinsurance after deductible |
| \$25 copayment \$40 copayment 20% coinsurance after deductible | \$25 copayment \$40 copayment 20% coinsurance after deductible | 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible |
| \$0 | \$0 | 20% coinsurance after deductible |
| 20% coinsurance after deductible | 20% coinsurance after deductible | 20% coinsurance after deductible |
| \$0 | \$0 | 20% coinsurance after deductible |
| 20% coinsurance per stay after deductible | 20% coinsurance per stay after deductible | 20% coinsurance after deductible |
| \$0 \$0 | \$0 \$0 | 20% coinsurance after deductible 20% coinsurance after deductible |
| 20% coinsurance after deductible | 20% coinsurance after deductible | 20% coinsurance after deductible |
| \$25 copayment \$40 copayment 20% coinsurance after deductible | \$25 copayment \$40 copayment 20% coinsurance after deductible | 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible |
| 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible | 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible | 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible |
| 20% coinsurance after deductible 20% coinsurance after deductible | 20% coinsurance after deductible 20% coinsurance after deductible | 20% coinsurance after deductible 20% coinsurance after deductible |
| \$25 copayment \$40 copayment If your doctor submits one bill for delivery, prenatal and postnatal care services, there is no copayment required for physician care. If your doctor bills for these services separately, your payment responsibility will be determined by the services received. | \$25 copayment \$40 copayment | 20% coinsurance after deductible 20% coinsurance after deductible |
| \$0 \$0 | \$0 \$0 | 20% coinsurance after deductible 20% coinsurance after deductible |
| 20% coinsurance per stay after deductible | 20% coinsurance per stay after deductible | 20% coinsurance after deductible |
| 20% coinsurance after deductible | 20% coinsurance after deductible | 20% coinsurance after deductible |
| 20% coinsurance after deductible | 20% coinsurance after deductible | 20% coinsurance after deductible |
| Tier 1 – \$10 copayment Tier 2 – \$20 copayment Tier 3 – \$35 copayment | Tier 1 – \$10 copayment Tier 2 – \$20 copayment Tier 3 – \$35 copayment | 20% coinsurance after deductible |
| Tier 1 – \$20 copayment Tier 2 – \$40 copayment Tier 3 – \$70 copayment 20% coinsurance, no deductible | Tier 1 – \$20 copayment Tier 2 – \$40 copayment Tier 3 – \$70 copayment 20% coinsurance, no deductible | 20% coinsurance after deductible 20% coinsurance after deductible |

The Local Choice 2012 Comparison of Statewide Plans (continued)

| Covered Services | Key Advantage Expanded In-Network You Pay | Key Advantage 250 In-Network You Pay |
|---|--|--|
| Routine vision - Blue View Vision Network (once every 12 months) <i>Routine eye exam</i> <i>Eyeglass lenses</i> <i>Eyeglass frames</i> <i>Contact lenses (in lieu of eyeglass lenses)</i> <ul style="list-style-type: none"> • Elective • Non-Elective <i>Lens Options</i> <ul style="list-style-type: none"> • UV coating, tints, standard scratch-resistant • Standard polycarbonate • Standard progressive • Standard anti-reflective • Other add-ons | \$25 copayment \$20 copayment Up to \$100 retail allowance** Up to \$100 retail allowance Up to \$250 retail allowance \$15 \$40 \$65 \$45 20% off retail | \$35 copayment \$20 copayment Up to \$100 retail allowance** Up to \$100 retail allowance Up to \$250 retail allowance \$15 \$40 \$65 \$45 20% off retail |
| Shots – allergy & therapeutic injections (at doctor's office, emergency room or outpatient hospital department) | 10% coinsurance, no deductible | 10% coinsurance after deductible |
| Skilled nursing facility stays (180-day per stay limit per member) <i>Facility services</i> <i>Professional provider services</i> | \$0 \$0 | \$0 \$0 |
| Spinal manipulations and other manual medical interventions (30 visits per plan year limit per member) <i>Primary care physicians</i> <i>Specialty care providers</i> | \$15 copayment \$25 copayment | \$20 copayment \$35 copayment |
| Surgery – see Hospital services | | |
| Therapy services <i>Cardiac Rehabilitation therapy, Chemotherapy, Radiation therapy, Respiratory therapy, Occupational therapy, Physical therapy, and Speech therapy</i> <i>Facility services</i> <i>Professional provider services</i> <ul style="list-style-type: none"> • Primary care physicians • Specialty care providers | 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible | 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible |
| Wellness services <i>Well child (office visits at specified intervals through age 6)</i> <ul style="list-style-type: none"> • Primary care physicians; • Specialty care providers; • Immunizations and screening tests <i>Routine wellness – age 7 & older</i> <ul style="list-style-type: none"> • Annual check-up visit (one per plan year) <ul style="list-style-type: none"> – Primary care physicians – Specialty care providers – Immunizations, lab and x-ray services • Routine screenings, immunizations, lab and x-ray services (outside of Annual check-up visit) <i>Preventive care (one of each per plan year)</i> <ul style="list-style-type: none"> • Gynecological exam • Pap test • Mammography screening • Prostate exam (digital rectal exam) • Prostate specific antigen test • Colorectal cancer screenings | No copayment, coinsurance, or deductible No copayment, coinsurance, or deductible No copayment, coinsurance, or deductible No copayment, coinsurance, or deductible | No copayment, coinsurance, or deductible No copayment, coinsurance, or deductible No copayment, coinsurance, or deductible No copayment, coinsurance, or deductible |

| Key Advantage 500 In-Network You Pay | Key Advantage 1000 In-Network You Pay | High Deductible Health Plan In-Network You Pay |
|--|--|---|
| \$40 copayment \$20 copayment Up to \$100 retail allowance** | \$40 copayment \$20 copayment Up to \$100 retail allowance** | Not covered Not covered Not covered |
| Up to \$100 retail allowance Up to \$250 retail allowance | Up to \$100 retail allowance Up to \$250 retail allowance | Not covered Not covered |
| \$15 \$40 \$65 \$45 20% off retail | \$15 \$40 \$65 \$45 20% off retail | Not covered Not covered Not covered Not covered Not covered |
| 20% coinsurance after deductible | 20% coinsurance after deductible | 20% coinsurance after deductible |
| | | |
| \$0 | \$0 | 20% coinsurance after deductible |
| \$0 | \$0 | 20% coinsurance after deductible |
| | | |
| \$25 copayment \$40 copayment | \$25 copayment \$40 copayment | 20% coinsurance after deductible 20% coinsurance after deductible |
| | | |
| | | |
| 20% coinsurance after deductible | 20% coinsurance after deductible | 20% coinsurance after deductible |
| 20% coinsurance after deductible 20% coinsurance after deductible | 20% coinsurance after deductible 20% coinsurance after deductible | 20% coinsurance after deductible 20% coinsurance after deductible |
| | | |
| No copayment, coinsurance, or deductible | No copayment, coinsurance, or deductible | No copayment, coinsurance, or deductible |
| | | |
| No copayment, coinsurance, or deductible | No copayment, coinsurance, or deductible | No copayment, coinsurance, or deductible |
| | | |
| No copayment, coinsurance, or deductible | No copayment, coinsurance, or deductible | No copayment, coinsurance, or deductible |
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